REINSTATEMENT APPLICATION FOR RESPIRATORY CARE PROFESSIONAL LICENSURE

ATTACH CHECK HERE

GEORGIA MEDICAL BOARD (GMB) USE ONLY

AP NUMBER	_____	**FILE NUMBER**	_____
RECEIVED	_____	**COMPLETED**	_____
TEMP PERMIT #	_____	**DATE ISSUED**	_____
LICENSE NUMBER	_____	**DATE REINSTATED**	_____
WITHDRAWN	_____	**DATE WITHDRAWN**	_____
DENIED	_____	**DATE DENIED**	_____

*** EFFECTIVE JULY 1, 2001 ALL FEES ARE NONREFUNDABLE***

F E E S A R E S U B J E C T T O C H A N G E

APPLICANT INFORMATION - REINSTATEMENT

I hereby make application for certification pursuant to the Georgia Respiratory Care Practice Act (O.C.G.A. 43-34-140) and submit the following statement concerning my age, moral character, education and practice.

1. US Social Security Number: _____ _____ _____ - _____ _____ - _____ _____ _____ _____

This information is authorized to be obtained and disclosed to state and federal agencies by O.C.G.A. § 19-11-1 and O.C.G.A. § 20-3-295, 42 U.S.C.A. § 651 and 20 U.S.C.A. § 1001. This information also may be disclosed to the National Practitioner's Data Bank (NPDB) or other state medical boards or regulatory agencies for license tracking purposes.

☐ **I do <u>not</u> wish this information to be released to the NPDB, other medical boards, or other regulatory agencies for license tracking purposes.**

PLEASE TYPE OR PRINT LEGIBLY.

2. LAST NAME	FIRST NAME	MIDDLE NAME

MAIDEN NAME	SEX M F	DATE OF BIRTH (MM/DD/YY)	PLACE OF BIRTH

3. Mailing address – This address will be used to mail application status information.			
STREET NUMBER STREET NAME			APARTMENT #
CITY	STATE	ZIP CODE	COUNTY
( ) (AREA CODE) HOME PHONE NUMBER	( ) (AREA CODE) WORK PHONE		@ E-MAIL ADDRESS

4. Are you certified/registered by the National Board of Respiratory Care? _____Yes _____No

5. Have you served in the armed forces?	IF YES, DATES OF SERVICE (MM/DD/YY – MM/DD/YY)
☐ Yes ☐ No ☐ Not applicable	_____
6. Have you been discharged?	IF YES, DATE OF DISCHARGE (MM/DD/YY) _____ TYPE OF DISCHARGE **(ATTACH A COPY OF YOUR DISCHARGE FORM – DD-214)** _____
☐ Yes ☐ No ☐ Not applicable	

RESPIRATORY CARE AND OTHER HEALTH RELATED LICENSES

If you are now, or ever have been licensed or certified to practice any health related profession in Georgia, in another state or country, you are required to complete the following information in chronological order.

State/Country	Date Certificate or License Issued Month/Day/Year	How Licensed and Type of Exam	Status of License/Certificate (Circle One)
		_____Rec. _____Exam	Active Inactive
		_____Rec. _____Exam	Active Inactive
		_____Rec. _____Exam	Active Inactive
		_____Rec. _____Exam	Active Inactive

APPLICANT QUESTIONNAIRE

INSTRUCTIONS: If you answer, "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. Failure to furnish complete documentation may result in a delay in the processing of your application. NOTE: To be considered for reinstatement, you must provide proof of having completed 30 hours of continuing education units (CEU's) within the last two years. For additional information concerning approved programs and credit hours, please visit http://rules.sos.state.ga.us/docs/360/13/10.pdf	**YES**	**NO**
1. Has any board or agency denied issuance of or pursuant to disciplinary proceeding refused renewal of certificate?	❑	❑
2. Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse during the last seven years? (If yes, provide the Board with all treatment history documentation to include diagnosis, treatment regimen, medical regimen, hospitalization, and on-going treatment/medication.)	❑	❑
3. Have you ever been convicted of a violation of any Federal (including military), State or Local statute?	❑	❑
4. Have you ever been denied the privilege of taking an examination given by any state licensing Board or been denied a certificate/license?	❑	❑
5. Has any state licensing Board revoked or suspended a certificate/license issued to you or taken other disciplinary action?	❑	❑
6. Have you ever been denied membership in any professional society or association?	❑	❑
7. Have you had any malpractice suits filed against you?	❑	❑
8. Have you ever voluntarily surrendered any professional license or certificate?	❑	❑
9. Are you in default on a state or federally funded and/or guaranteed school loan?	❑	❑
10. To your knowledge, are you the subject of an investigation by any licensing Board or agency as of the date of this application?	❑	❑
11. Have you ever been dismissed or resigned while under investigation at a hospital?	❑	❑
12. Have you ever defaulted on child support payments?	❑	❑
13. Did you include a copy of your CV or résumé with this application packet?	❑	❑
14. Date you began working as a Respiratory Therapist in Georgia? DATE:_____/_____/_____		
15. Have you completed 30 hours of continuing education units (CEU's)?	❑	❑

AFFIDAVIT OF APPLICANT

TOP OF PHOTO (HEAD)

PHOTO AREA
PASTE A 2 ¼" X 3"
PHOTO HERE.

PHOTO MUST BE OF
YOUR HEAD
AND SHOULDER AREAS ONLY

BOTTOM OF PHOTO (SHOLDERS)

Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Georgia Law that authorizes collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards or other governmental or law enforcement agencies.

I acknowledge and state that I have read and am familiar with the Respiratory Care Practice Act and rules pertaining thereto. I further state that by filing this application for certification as a Respiratory Care Professional in the State of Georgia, I authorize and consent to have an investigation made as to my moral character, profession reputation and fitness to practice as a Respiratory Care Professional. I agree to give any further information that may be required in reference to my past record. I understand that I will not receive a copy of the report or know its contents and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board or Court Order.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, Federal or foreign) court, association, institution, or any other organization having control of any documents, records or other such information pertaining to me, to furnish to the Composite State Board of Medical Examiners any such documents, records regarding charges or complaints filed against me formal or informal, pending or closed, or any other pertinent data and permit the Georgia Composite State Board of Medical Examiners or any of its agents or representatives to inspect and make copies of such documents, records or other information, in connection with this application, subsequent to practice there under.

I authorize and request the Georgia Composite State Board of Medical Examiners to obtain any criminal history information concerning me from any authorized law enforcement agency including but not limited to the Georgia Crime Information Center (GCIC) and the National Crime Information Center (NCIC).

I hereby release, discharge and exonerate the Georgia Composite State Board of Medical Examiners for any and all liability of every nature and kind arising out of the furnishing or inspections of such documents, records or other information or any investigation made by the Georgia Composite State Board of Medical Examiners to release information, material, documents, orders or the like relating to me or to this application to any other agency or any other agency of the State of Georgia, the medical licensing agency of any other state or territory of the United States, or Province of Canada, the Federation of State Medical Boards, or the US Inc., law enforcement agency, hospital or other appropriate agencies as determined by the Board.

This is to certify that the foregoing information is true and correct to the best of my knowledge; I understand that pursuant to the Official Code of Georgia Annotated. Section 43-43-46, any person who shall give false or forged evidence of any kind to the Board in connection with an application, shall be guilty of a felony and upon conviction thereof, shall be punished by paying a fine of not less than $500 nor more than $1000 or by imprisonment from two to five years or both.

SIGNATURE OF APPLICANT	DATE	CITY	COUNTY	STATE

PRINTED NAME OF APPLICANT	Being duly sworn, says that he/she is the person who executed the above application and that all the statements herein contained are true and that the attached photo is a true photo of the applicant. **NOTE: THE APPLICANT SIGNATURE <u>DATE</u> AND THE NOTARY SIGNATURE <u>DATE MUST MATCH.</u>**	NOTARY SEAL MUST BE IMPRINTED HERE

Sworn and subscribed before me this _____day of _____20_____, _

_____(Notary Public)

My Commission Expires

_____

Temp. Permit No. _____

FORM B1
RESPIRATORY CARE REINSTATEMENT REFERENCE FORM

In order for the Composite State Board of Medical Examiners to adequately evaluate the applicant named below for certification to practice as a Respiratory Care Practitioner in the State of Georgia, please complete all pertinent sections in detail. This reference form must be completed and signed by a **licensed physician** with whom the **applicant practices with at the time of application, or who is in charge of the Respiratory Program**. **If a Medical Director Reference Form cannot be submitted, a Prospective Employer's Reference Form (Form B11) may be submitted instead.** This form must be mailed **directly from the physician to** the **Medical Board.**

Composite State Board of Medical Examiners
Respiratory Care Professionals Unit
2 Peachtree Street, N.W. – 36th Floor
Atlanta, GA 30303

Section 1: - To Be Completed by Applicant:

Name: Last:_____First:_____ M.I.:____Maiden: _____

Mailing Address: _____

_____

Telephone Number: _____

Place of Employment or College Clinical:_____

City & State of location indicated above: _____

Section 2: To be completed by Physician or Program Director; however, the Medical Director must sign the form:

Please evaluate the applicant in the following areas:

	Excellent	Good	Average	Poor	Not able to make judgment
Dependability	☐	☐	☐	☐	☐
Quality of Work	☐	☐	☐	☐	☐
Professional Responsibility	☐	☐	☐	☐	☐

Reference Form Continued On Next Page

FORM B1 - RESPIRATORY CARE REINSTATEMENT REFERENCE FORM (continued)

Date Employment Started: month/ day/ year/

In your professional opinion is the applicant capable of performing competently as a Respiratory Care Professional? ☐ Yes ☐ No

Would you recommend certification based on applicant's abilities? ☐ Yes ☐ No
If no, please explain.

I hereby certify that the above applicant is or has been employed under my supervision as a health professional in Respiratory Care *from* (mm/yy) / *to* (mm/yy) /

Applicant worked ☐ full time ☐ part time, approximately ___ hours per week.

Would you rehire (if applicable) ☐ Yes ☐ No? If no, please explain.

Additional Comments:

Name of Business or School:

City & State of above location:

Physician's Name: *(please type or print)*

Physician's Signature:

License Number: State of Licensure:

Business Telephone Number: Date:

Please Mail to: **Composite State Board of Medical Examiners**
Respiratory Care Professional Unit
2 Peachtree Street N.W., - 36th Floor
Atlanta, GA 30303

FORM B11
RESPIRATORY CARE REINSTATEMENT REFERENCE FORM

To Be Completed by Prospective Employer:
Please provide all information requested:

In order for the Composite State Board of Medical Examiners to adequately evaluate the applicant named below for certification to practice as a Respiratory Care Practitioner in the State of Georgia, please complete all pertinent sections in detail. This reference form must be completed and signed by a licensed physician with whom the **applicant intends to practice.** This form must be mailed **directly from the physician to** the **Medical Board.**

Composite State Board of Medical Examiners
Respiratory Care Professionals Unit
2 Peachtree Street, N.W. – 36th Floor
Atlanta, GA 30303

I hereby certify that _____ will be employed under my
Name of Applicant

supervision as a Health Care Professional in Respiratory Care, effective_____/_____/_____.

Applicant will work ☐ full time ☐ part time, approximately _____ hours per week.

Additional Comments: _____

_____

_____.

Physician Name _____
Please print or type

Physician Signature _____ _____
Date

License Number & State _____

Business Name _____

Mailing Address _____

_____
City State Zip Code

Business Telephone _____

FORM C1
RESPIRATORY CARE REINSTATEMENT
LICENSURE VERIFICATION FORM

This form should be sent to each state where you hold or have held a license/certificate to practice Respiratory Care. This form may be photocopied.

I am applying for certification under the Respiratory Care Practices Act with the Composite State Board of Medical Examiners. The Georgia Board requires that your Board complete this form in order that I may be considered for certification. By signing this form, I give my consent to release any information, favorable or otherwise, for their review in considering me for a Georgia certificate. As soon as possible, please forward the completed form to the Board at the address listed below.

Section 1 (to be completed by applicant):

My certificate number _____ was issued by your State Board on _____/_____/_____ on the basis of:

☐ NBRC ☐ Grandparent Provision ☐ Graduation from an approved school

☐ Other_____

Name ***(Please print or type)*** _____

Signature _____

Street Address _____ City, State & Zip Code _____

Section 2 (to be completed by an official of the above referenced Licensing Board):

Respiratory Care Professional Certificate No. _____ to practice as a Respiratory Care Professional in the State of _____ was issued to above-mentioned Respiratory Care Professional on month/ day/ year/ .

Is certificate in good standing? ☐ Yes ☐ No Date license expires(d) (mm/yy) _____/_____

Has any disciplinary action ever been taken against the above Respiratory Care Professional including but not limited to suspension or revocation? ☐ Yes ☐ No

If yes, please furnish details:_____

_____

Signed _____

Title _____ **State Seal**

State Board _____

Date _____

Please Mail to: Georgia Composite State Board of Medical Examiners
Respiratory Care Professional
2 Peachtree Street, N.W., 36th Floor
Atlanta, GA 30303